FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037853

Facility Name: Heritage Manor-Dwight

Address: 300 East Mazon Avenue (Number) Dwight (City) 60420 (Zip Code)

County: Livingston

Telephone Number: (815) 584-1240 **Fax #** ( )

HFS ID Number: 370909086015

Date of Initial License for Current Owners: 1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig L. Ater

(Title) Senior V.P. & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,616	6,930	3,476	24,022	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	13,616	6,930	3,476	24,022	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.54%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1992

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,476

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Dwight # 0037853 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	169,159	9,679		178,838		178,838	4,061	182,899			1
2	Food Purchase		129,476		129,476		129,476		129,476			2
3	Housekeeping	87,743	14,172		101,915		101,915	4	101,919			3
4	Laundry	43,992	12,376		56,368		56,368		56,368			4
5	Heat and Other Utilities			118,601	118,601		118,601	1,282	119,883			5
6	Maintenance	49,511	25,388	26,309	101,208		101,208	10,740	111,948			6
7	Other (specify):*											7
8	**TOTAL General Services**	350,405	191,091	144,910	686,406		686,406	16,087	702,493			8
	B. Health Care and Programs											
9	Medical Director			11,208	11,208		11,208		11,208			9
10	Nursing and Medical Records	989,476	106,595	20,894	1,116,965		1,116,965		1,116,965			10
10a	Therapy		267,210	285,095	552,305	(403,154)	149,151	117,394	266,545			10a
11	Activities	57,060	7,308		64,368		64,368		64,368			11
12	Social Services	42,880		3,539	46,419		46,419		46,419			12
13	CNA Training		500		500		500	1,443	1,943			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,089,416	381,613	320,736	1,791,765	(403,154)	1,388,611	118,837	1,507,448			16
	C. General Administration											
17	Administrative	63,161			63,161		63,161	62,259	125,420			17
18	Directors Fees							4,622	4,622			18
19	Professional Services			224,308	224,308		224,308	(211,466)	12,842			19
20	Dues, Fees, Subscriptions & Promotions			95,211	95,211	(50,370)	44,841	(29,750)	15,091			20
21	Clerical & General Office Expenses	93,025	7,846	15,597	116,468		116,468	128,508	244,976			21
22	Employee Benefits & Payroll Taxes			340,622	340,622		340,622	33,448	374,070			22
23	Inservice Training & Education			726	726		726	1,083	1,809			23
24	Travel and Seminar			8,706	8,706		8,706	(6,707)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,074	61,074		61,074	1,640	62,714			26
27	Other (specify):*			45	45		45		45			27
28	**TOTAL General Administration**	156,186	7,846	746,289	910,321	(50,370)	859,951	(16,363)	843,588			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,596,007	580,550	1,211,935	3,388,492	(453,524)	2,934,968	118,561	3,053,529			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Dwight #0037853 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,384	34,384		34,384	10,899	45,283			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,438	15,438		15,438	18,030	33,468			32
33	Real Estate Taxes			41,614	41,614		41,614		41,614			33
34	Rent-Facility & Grounds			198,458	198,458		198,458	5,629	204,087			34
35	Rent-Equipment & Vehicles			6,289	6,289		6,289	(570)	5,719			35
36	Other (specify):*											36
37	**TOTAL Ownership**			296,183	296,183		296,183	33,988	330,171			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					403,154	403,154		403,154			39
40	Barber and Beauty Shops			7,651	7,651		7,651		7,651			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					50,370	50,370		50,370			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			7,651	7,651	453,524	461,175		461,175			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,596,007	580,550	1,515,769	3,692,326		3,692,326	152,549	3,844,875			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,982)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(944)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(980)	20		17
18	Fines and Penalties				18
19	Entertainment	(15,273)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,358)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(32,678)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,215)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	205,764		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 205,764		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 152,549		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Manor-Dwight

ID# 0037853

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	$ Amount	Sch. V Line Reference	
1				1
2				2
3				3
4				4
5		(1,982)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(980)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,358)	19	22
23				23
24		0	27	24
25		(32,678)	20	25
26				26
27				27
28				28
29		0	23	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(36,998)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heritage Manor-Dwight **#** 0037853 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,061	0	0	0	0	0	0	0	0	4,061	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,282	0	0	0	0	0	0	0	0	1,282	5
6	Maintenance	0	0	10,740	0	0	0	0	0	0	0	0	10,740	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	16,087	0	0	0	0	0	0	0	0	16,087	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	117,394	0	0	0	0	0	0	0	0	0	117,394	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,443	0	0	0	0	0	0	0	0	1,443	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	117,394	1,443	0	0	0	0	0	0	0	0	118,837	16
	C. General Administration													
17	Administrative	0	0	62,259	0	0	0	0	0	0	0	0	62,259	17
18	Directors Fees	0	0	4,622	0	0	0	0	0	0	0	0	4,622	18
19	Professional Services	(1,358)	(222,950)	12,842	0	0	0	0	0	0	0	0	(211,466)	19
20	Fees, Subscriptions & Promotions	(33,658)	0	3,908	0	0	0	0	0	0	0	0	(29,750)	20
21	Clerical & General Office Expenses	0	0	128,508	0	0	0	0	0	0	0	0	128,508	21
22	Employee Benefits & Payroll Taxes	0	0	33,448	0	0	0	0	0	0	0	0	33,448	22
23	Inservice Training & Education	0	0	1,083	0	0	0	0	0	0	0	0	1,083	23
24	Travel and Seminar	(15,273)	0	8,566	0	0	0	0	0	0	0	0	(6,707)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,640	0	0	0	0	0	0	0	0	1,640	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(50,289)	(222,950)	256,876	0	0	0	0	0	0	0	0	(16,363)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,289)	(105,556)	274,406	0	0	0	0	0	0	0	0	118,561	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Heritage Manor-Dwight **#** 0037853 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	10,899	0	0	0	0	0	0	0	10,899	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(944)	0	0	18,974	0	0	0	0	0	0	0	18,030	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,629	0	0	0	0	0	0	0	5,629	34
35	Rent-Equipment & Vehicles	(1,982)	0	0	1,412	0	0	0	0	0	0	0	(570)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,926)	0	0	36,914	0	0	0	0	0	0	0	33,988	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(53,215)	(105,556)	274,406	36,914	0	0	0	0	0	0	0	152,549	45

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	222,950	Heritage Enterprises, Inc.	100.00%		(222,950)	4
5	V								5
6	V	10a	Adjustment for Related Organization	267,167	GreenTree Pharmacy	100.00%	384,561	117,394	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 490,117			$ 384,561	$ * (105,556)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 4,061	$ 4,061	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				4	4	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,282	1,282	19
20	V	6	Maintenance				10,740	10,740	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,443	1,443	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				62,259	62,259	29
30	V	18	Directors Fees				4,622	4,622	30
31	V	19	Professional Services				12,842	12,842	31
32	V	20	Fees, Subscription, Promotions				3,908	3,908	32
33	V	21	Clerical & General Office Expenses				128,508	128,508	33
34	V	22	Employee Benefits & Payroll Taxes				33,448	33,448	34
35	V	23	Inservice Training & Education				1,083	1,083	35
36	V	24	Travel and Seminar				8,566	8,566	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,640	1,640	38
39	Total			$			$ 274,406	$ * 274,406	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$	$ 0	15
16	V	30	Depreciation					10,899	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					18,974	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,629	20
21	V	35	Rent-Equipment & Vehicles					1,412	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 36,914	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	$ 14,048	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	15,755	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	9,381	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	12,225	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	6,032	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	6,761	Ln 17 & 18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	2,679	Ln 17 & 18	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 66,881		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington,Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	$ 115,289	$ 115,276	92	$ 4,061	1
2	2	Food Purchase	Beds	2,612	25	7	0	92	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	92	4	3
4	4	Laundry	Beds	2,612	25	0	0	92	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	92	1,282	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	92	10,740	6
7	7	Other	Beds	2,612	25	0	0	92	0	7
8	9	Medical Director	Beds	2,612	25	0	0	92	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	92	0	9
10	11	Activities	Beds	2,612	25	0	0	92	0	10
11	12	Social Service	Beds	2,612	25	0	0	92	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	92	1,443	12
13	14	Program Transportation	Beds	2,612	25	0	0	92	0	13
14	15	Other	Beds	2,612	25	0	0	92	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	92	62,259	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	92	4,622	16
17	19	Professional Services	Beds	2,612	25	364,592	0	92	12,842	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	92	3,908	18
19	21	Clerical & General Office Expens	Beds	2,612	25	3,648,522	3,309,912	92	128,508	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	92	33,448	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	92	1,083	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	92	8,566	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	92	1,640	24
25	TOTALS					$ 7,790,758	$ 5,312,885		$ 274,406	25

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	$	$	92	$	1
2	30	Depreciation	Beds	2,612	25	309,426		92	10,899	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			92		3
4	32	Interest	Beds	2,612	25	538,695		92	18,974	4
5	33	Real Estate Taxes	Beds	2,612	25			92		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		92	5,629	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		92	1,412	7
8	36	Other	Beds	2,612	25			92		8
9	38	Medically Nec Transportation	Beds	2,612	25			92		9
10	39	Ancillary Service Centers	Beds	2,612	25			92		10
11	40	Barber and Beauty Shops	Beds	2,612	25			92		11
12	41	Coffee and Gift Shops	Beds	2,612	25			92		12
13	42	Other	Beds	2,612	25			92		13
14								92		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,048,023	$		$ 36,914	25

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							15,438	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 15,438	9
	B. Non-Facility Related*											
10	Interest Income										(944)	10
11												11
12	Allocated Interest										18,974	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 18,030	14
15	TOTALS (line 9+line14)						$	$			$ 33,468	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 41,512	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 40,549	2
3. Under or (over) accrual (line 2 minus line 1).	$ (963)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 42,577	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 41,614	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	32,389	8
2001	35,335	9
2002	37,148	10
2003	36,246	11
2004	39,461	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Dwight COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0037853

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-04-483-011	Heritage Manor-Dwight	$ 696.00	$ 696.00
2.	05-04-483-001		$ 38,832.00	$ 38,832.00
3.	05-04-483-002		$ 1,021.00	$ 1,021.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,549.00	$ 40,549.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,294 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [xx] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1992 Improvements				8,456						9
10	1993 Improvements				586,243						10
11	1994 Improvements				12,874						11
12	1995 Improvements				496						12
13	Water Heater			1996	7,350						13
14	Interior Rehab (see attached)			1997	118,804						14
15	Garbage Disposal			1997	983						15
16											16
17	Parking Lot			1998	2,717						17
18	Interior Rehab			1998	17,242						18
19											19
20	Alarm Repair/Replacement			1999	1,120						20
21	Air Conditioning Unit			1999	2,461						21
22	Shower Room Repair			1999	6,345						22
23											23
24	Fire Dampers			2000	1,290						24
25	Boiler			2000	1,540						25
26											26
27	Water Heater			2001	7,200						27
28	Window Replacements			2001	4,437						28
29	Flooring -- Kitchen			2001	604						29
30	Code Alert System			2001	933						30
31	Motor Reolacement--A/C			2001	1,398						31
32											32
33											33
34	C/O Allocation							10,899	10,899		34
35	Book Depreciation					17,972		17,972		717,913	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	A/C compressor	2002	$ 582	$		$	$	$	37
38	Boiler Tubing	2002	11,208						38
39	Backflow preventor	2002	2,803						39
40	Wallcoverings	2002	21,813						40
41	Compressor	2002	1,175						41
42	Rooftop A/C unit	2002	20,169						42
43									43
44	Wallcoverings	2003	1,528						44
45	Rooftop A/C unit	2003	(9,766)						45
46	Exterior Doors	2003	3,121						46
47	30 Gallon Tank	2003	1,056						47
48	Compressor	2003	1,839						48
49	Walk in Freezer	2003	3,301						49
50	Disposal	2003	771						50
51									51
52	Fire Supression System	2004	1,523						52
53	Pump	2004	714						53
54	Boiler	2004	13,085						54
55	Water Softener	2004	1,467						55
56	Parking Lot Sealant	2004	2,800						56
57	Laundry drain	2004	2,350						57
58									58
59	Motor --Circulator	2005	1,674						59
60	Water Heater	2005	10,113						60
61	Kitchen Door	2005	240						61
62	A/C compressor	2005	175						62
63	Generator Panel	2005	833						63
64	Closet Rehab	2005	1,137						64
65	Exterior Lights	2005	127						65
66	A/C compressor	2005	4,597						66
67	Kitchen Water Heater	2005	1,059						67
68	Sidewalks	2005	7,450						68
69	Boiler Repair	2005	1,967						69
70	TOTAL (lines 4 thru 69)		$ 893,404	$ 17,972		$ 28,871	$ 10,899	$ 717,913	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 893,404	$ 17,972		$ 28,871	$ 10,899	$ 717,913	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 893,404	$ 17,972		$ 28,871	$ 10,899	$ 717,913	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 330,208	$ 16,412	$ 16,412	$		$ 304,882	71
72	Current Year Purchases	10,413						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 340,621	$ 16,412	$ 16,412	$		$ 304,882	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,234,025	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,384	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,283	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,899	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,022,795	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Dwight Contintal Manor
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		92	1992	$ 198,458	10	10	3
4	Additions							4
5								5
6								6
7	TOTAL		92		$ 198,458 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [xx] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 2002
Ending 2012

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ 198,458
13.	/2007	$ 198,458
14.	/2008	$ 198,458

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [xx] YES [ ] NO
16. Rental Amount for movable equipment: $ 5,719 Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		500		500
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 500	$	$ 500
10	SUM OF line 9, col. 1 and 2 (e)	$ 500			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 135,978	$		$ 135,978	1
2	Licensed Speech and Language Development Therapist		hrs			21,924			21,924	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			108,643	0		108,643	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				384,604		384,604	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					18,550			18,550	13
14	TOTAL			$		$ 285,095	$ 384,604		$ 669,699	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Dwight # 0037853 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,785	$	1
2	Cash-Patient Deposits	5,388		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	297,433		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,143		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	517,877		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 849,626	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	893,405		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	340,621		16
17	Accumulated Depreciation (book methods)	(1,022,795)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 211,231	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,060,857	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 74,572	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,388		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	153,881		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,577		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 278,600	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 278,600	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 782,257	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,060,857	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Dwight **#** 0037853 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 770,300	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 770,300	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	11,957	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 11,957	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 782,257	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,593,199	1
2	Discounts and Allowances for all Levels	(1,069,487)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,523,712	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	689,511	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 689,511	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,009	12
13	Barber and Beauty Care	10,057	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	474,050	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 490,116	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	944	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 944	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,704,283	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	686,406	31
32	Health Care	1,791,765	32
33	General Administration	910,321	33
	B. Capital Expense		
34	Ownership	296,183	34
	C. Ancillary Expense		
35	Special Cost Centers	7,651	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,692,326	40
41	**Income before Income Taxes (line 30 minus line 40)****	11,957	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 11,957	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,928	2,152	$ 45,698	$ 21.24	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,310	6,056	114,352	18.88	3
4	Licensed Practical Nurses	13,781	14,945	259,568	17.37	4
5	CNAs & Orderlies	45,070	48,842	507,487	10.39	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,762	4,053	62,371	15.39	8
9	Activity Director					9
10	Activity Assistants	5,231	5,708	57,060	10.00	10
11	Social Service Workers	3,325	4,241	42,880	10.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,799	20,151	169,159	8.39	15
16	Dishwashers					16
17	Maintenance Workers	4,069	4,276	49,511	11.58	17
18	Housekeepers	10,128	11,007	87,743	7.97	18
19	Laundry	6,324	6,700	43,992	6.57	19
20	Administrator	1,900	2,080	63,161	30.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,546	6,399	93,025	14.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,173	136,610	$ 1,596,007 *	$ 11.68	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		11,208		36
37	Medical Records Consultant		1,264		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,400		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,539		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,411		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	12	$ 353		50
51	Licensed Practical Nurses	509	12,719		51
52	Certified Nurse Assistants/Aides	60	1,200		52
53	TOTAL (lines 50 - 52)	581	$ 14,272		53

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Randy Provence	admin		$ 63,161
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,161

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Mgt Fees	$ 222,950
		0
		0
		0
Legal--Adjusted to Zero		1,358
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 224,308

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,000
Unemployment Compensation Insurance	28,910
FICA Taxes	122,095
Employee Health Insurance	130,708
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	19,909
Employee Benefits - central office	33,448
TOTAL (agree to Schedule V, line 22, col.8)	$ 374,070

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	4,245
Health Care Worker Background Check	
(Indicate # of checks performed)	250
Central Office Allocation	3,908
Promotional Advertising	21,320
Public Relations	11,358
Dues and Subscriptions	6,398
License and Fees	1,270
Less: Public Relations Expense	(11,358)
Non-allowable advertising	(980)
Yellow page advertising	(21,320)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,091

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,101
	487
Seminar Expense	5,118
	(15,273)
	8,566
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Manor-Dwight # 0037853 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **50,370**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **1,155**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

BASIC CHARGE-PRIVATE & VA	-3,267,176	
PRIVATE ASSESSMENT TAX INCOME		
BASIC CHARGE-IPA	0	
BASIC CHARGE-MEDICARE	0	
DAY CARE/HOME CARE		
LIGHT NURSING CARE	-60,600	
MEDIUM NURSING CARE		
HEAVY NURSING CARE		
SKILLED NURSING CARE		
NURSING SUPPLIES-PRIVATE	-238,125	
NURSING SUPPLIES-IPA		
NURSING SUPPLIES MED PT A		
NURSING SUPPLIES MED PT B		
DRUGS	-474,050	
DRUGS-OTHER		
PT-PRIVATE	-689,511	
PT-IPA		
PT-MEDICARE PART A		
PT-MEDICARE PART B		
PUBLIC AID ASSESSMENT INC		
LABORATORY INCOME		
SPEECH/OT-PRIVATE		
SPEECH/OT-IPA		
SPEECH/OT-MED PART A		
SPEECH/OT MED PART B		
IPA DISCOUNTS	1,069,487	
MEDICAID PART B DISCOUNT		
MEDICARE DISCOUNTS		
ASSESSMENT TAX EXPENSE		
RENT INCOME	0	
BEAUTY SHOP	-10,057	
ACTIVITY FUND INCOME	-3,250	
VENDING INCOME/EXPENSE	-2,759	
MANAGEMENT FEES		
EQUIPMENT RENTAL	-27,298	
RESIDENT TRANSPORTATION	0	
MISC INCOME	0	
GENERAL & ADMINIST WAGES	89,549	93,025
ADMINISTRATOR WAGES	63,161	63,161
VACATION & SICK - G&A	3,476	
EMPLOYEE BENEFITS	7,999	340,622
EMPLOYEE HEPETITIS VACCIN	0	
EMPLOYEE SCHOLORSHIP WAC	7,559	
EMPLOYEE SCHOLORSHIP COS	4,351	
DIRECTORS FEES		
OFFICE SUPPLIES	7,846	7,846
TELEPHONE	15,597	15,597
TRAINING & EMPLOYEE DEVL	726	726
GENERAL TRAVEL	3,101	8,706
MEAL EXPENSE FOR TRAVEL	487	
EDUCATION & SEMINAR	5,118	
HELP WANTED ADVERTISING	4,245	95,211
PROMOTIONAL ADVERTISING	21,320	
PUBLIC RELATIONS	11,358	
LICENSES & FEES	51,640	
DUES & SUBSCRIPTIONS	6,398	
CONTRIBUTIONS	0	
PROFESSIONAL FEES	1,358	224,308
MEDICAL DIRECTOR	11,208	11,208
UTILIZATION REVIEW	0	
OTHER PHYSICIAN FEES	0	
MEDICAL RECORDS CONSULT	1,264	
PHARMACIST FEES	2,400	
SOC SERV/ACT CONSULT	3,539	3,539
TV RENTAL	3,478	
INCOME TAXES		45
BACKGROUND CHECKS	250	
PAYROLL TAXES	144,698	
PAYROLL TAXES ADMINIST	6,307	
GROUP INSURANCE	130,708	
LIABILITY INSURANCE	61,074	61,074
INSURANCE-OWNERS		
WORKMENS COMP INSURANCE	39,000	
CENTRAL OFFICE FEES	222,950	
BAD DEBTS	0	
LOST ITEMS-RESIDENTS	45	
MISCELLANEOUS	0	
REAL ESTATE TAXES	41,614	41,614
LEASED EQUIPMENT	2,811	6,289
MAINTENANCE SALARIES	46,424	49,511
MAINTENANCE SICK & VAC	3,087	
ELECTRIC	42,662	118,601
NATURAL GAS	43,381	
HEATING & DEISEL OIL		
WATER & SEWER	32,558	
TRASH COLLECTION	7,989	26,309
PROPERTY PLANT REPLACEMN	1,585	25,388
GENERAL REPAIR & MAINT	23,803	
MAINTENANCE CONTRACTS	18,320	
DIETARY WAGES	158,301	169,159
DIETARY SICK & VAC	10,858	
SALES TAX		
FOOD PURCHASES	130,631	129,476
SUPPLIES-DISHWASHING	2,413	9,679
DIETARY REPLACEMENT	2,053	
KITCHEN SUPPLIES-PAPER	5,213	
MEAL CREDIT	-1,155	
LAUNDRY WAGES	42,267	43,992
LAUNDRY SICK & VAC	1,725	
LAUNDRY REPLACEMENT	8,040	12,376
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	4,336	
HOUSEKEEPING WAGES	82,058	87,743
HOUSEKEEPING SICK & VAC	5,685	
HOUSEKEEPING SUPPLIES	5,636	14,172
HOUSEKEEPING SUPPLIES-PPR	8,536	
RN WAGES-MEDICARE		989,476
RN WAGES-NON MEDICARE	107,690	
DON WAGES	45,698	
ADON	0	
RN SICK & VACATION	6,662	
LPN WAGES-MEDICARE	0	
LPN WAGES-NON MEDICARE	246,728	
LPN WAGES OTHER		
LPN SICK & VACATION	12,840	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	450,254	
WARD CLERKS		
AIDE VACATION & SICK	57,233	
CONTRACT NURSES-RN	353	
CONTRACT NURSES-LPN	12,719	
CONTRACT NURSES-AIDES	1,200	
NURSE AIDE TRAINING WAGES	0	0
NURSE AID TRAINING EXP	500	500
NURSE AIDE TRAINING REIMB	0	
REHAB WAGES	58,382	
REHAB SICK & VAC	3,989	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	84,201	106,595
NURSING SUPPLIES	14,124	
REPLACEMENT-NURSING	8,270	
NURSING OTHER	2,958	20,894
DRUG PURCHASES	126,288	267,210
DRUG PURCHASES-OTHER	140,922	
LABORATORY SERVICES	18,550	285,095
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITES WAGES	53,099	57,060
ACTIVITIES SICK & VAC	3,961	
ACTIVITIES SUPPLIES	7,308	7,308
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	108,643	
PT SUPPLIES	0	
SOCIAL SERVICE WAGES	36,692	42,880
SOCIAL SERVICE SICK & VAC	6,188	
SOCIAL SERVICE EXPENSES	0	0
OT FEE	135,978	
SOCIAL THERAPIST FEE	0	0
SPEECH THERAPY FEE	21,924	
BEAUTICIAN WAGES		0
BEAUTICIAN SICK & VAC		
BEAUTICIAN FEES	7,651	7,651
BEAUTY SHOP SUPPLIES	0	0
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC		
VOL COORD SUPPLIES	0	
RENT	198,458	198,458
INTEREST EXPENSE	15,438	15,438
DEPRECIATION	34,384	34,384
LOAN FEE AMORTIZATION	0	
INTEREST INCOME	-944	
MISC NON-OPERATING INCOM	0	
INCOME TAXES	0	
	3,691,382	3,692,326
		944
	-11,957	
	(NET INCOME)	
	0	

						2,612	92	3,471,750	71,391,262		
	Name	Title	Function	Total Pay	usted by Mgmt F	otal # Beds	acility # Be	on-Nursing Hor	Nursing Home	This Facility	
###	Susie Jefferson	Director	Manageme	418,245	418,245			19,396	398,849	14,048	
###	Tom Jefferson	Secretary	Manageme	0	0			0	0	0	
###	Craig Hart	Chairman	Manageme	469,049	469,049			21,752	447,297	15,755	
###	Cheryl Lowney	Executive Vice Presic	Manageme	279,290	279,290			12,952	266,338	9,381	
###	Steve Wannemache	President	Manageme	363,969	363,969			16,879	347,090	12,225	
###	Connie Hoselton	Sr Vice President	Manageme	179,584	179,584			8,328	171,256	6,032	
###	Craig Ater	Sr Vice President	Manageme	201,279	201,279			9,334	191,945	6,761	
	Ben Hart			79,758	79,758			3,699	76,059	2,679	
13				1,991,174	1,991,174				1,898,834	66,881	